

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 3-11-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visit on 10-7-03 was not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 5-19-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The carrier denied CPT Code 99080-73 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requester submitted relevant information to support delivery of service.

Recommend reimbursement of CPT Code 99080-73 for \$15.00.

CPT Code 90808 for dates of service 10-8-03, 10-15-03 and 11-7-03 was denied with an E denial code indicating that it was denied for extent. A review of the TWCC database reveals that a TWCC-21 was not filed with the Commission disputing compensability; therefore, this review will be based entirely upon the *Medicare Fee Schedule*. In accordance with Rule 134.202(d)(2) reimbursement shall be the least of the MAR amount or the health care provider's usual and customary charge. **Recommend reimbursement of \$164.64 for each of three dates of service. This is a total of \$493.92.**

CPT Code 90901 for dates of service 10-8-03, 10-15-03 and 11-7-03 was denied with an E denial code indicating that it was denied for extent. A review of the TWCC database reveals that a TWCC-21 was not filed with the Commission disputing compensability; therefore, this review will be based entirely upon the *Medicare Fee Schedule*. In accordance with Rule 134.202(d)(2) reimbursement shall be the least of the MAR amount or the health care provider's usual and customary charge. **Recommend reimbursement of \$53.88 for each of three dates of service. This is a total of \$161.64.**

ORDER.

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees:

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable for dates of service 10-7-03 through 11-7-03 in this dispute.

This Decision and Order is hereby issued this 6th day of October, 2004.

Donna Auby

Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 19, 2004

AMENDED DECISION

RE:

MDR Tracking #: M5-04-2069-01

IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Physical Medicine & Rehabilitation, who is also a chiropractor, and who is board certified and has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

Records received for review are as follows:

- Note from _____
- Biofeedback notes from _____
- _____, other sundry information

This patient is a now 37 year old male with a date of injury on ____ where he suffered a right foot contusion. He is reported 5'9" in height and approximately 280 pounds. By body mass index he would be obese. It appears that this patient has been followed for right foot complaints and was seen by _____ on 10/31/02. No fractures were found. He then was again seen by _____ on 6/12/03 and in this note it states that the patient had been seen by _____, _____ and _____. He has had a three phase bone scan since he was last seen and this was normal. He has had EMG studies that were normal. He is on Vioxx. He has complaints of foot pain with standing and walking. He is off work. On this examination he was able to heel and toe raise. There was no effusion, swelling, no tenderness to palpation, no loss of motion. He had good strength of the foot. There was no atrophy. There was no intrinsic muscle wasting of the foot. MRI scans are reported from 8/18/02 which he states are normal. X-rays of the foot are normal. Notes from _____, are with an impression of degenerative joint disease with powerful collision. He has also been seen by _____, with an impression on 2/5/03 of post traumatic pain of the dorsal foot, right superficial peroneal nerve which has improved progressively. Assessment remains contusion of the right foot. He feels he does not require continued healthcare, nor future treatment other than a self directed home exercise program and over the counter medications in the form of anti-inflammatories. He feels that he can work as of 6/13/03 without restrictions. _____, sees this patient again on 3/25/04 for a return to work evaluation. His only findings are very slight. He has a two cm by two cm slightly swollen area at the dorsum of the right foot which is similar to a synovial cyst. However, this is very slight. He has good range of motion and no other specific findings. He feels he is not a surgical candidate and he feels once again for the third time that he feels no ongoing or continued treatment is necessary. There is a peer review performed by _____, physical medicine and rehabilitation, on 2/26/03 and this was reviewed.

Requested Service(s)

Please review and address the medical necessity of outpatient services of office visit for claimant on 10/7/03.

Decision

I agree with the insurance carrier that this office visit and subsequent office visits of biofeedback and psychological counseling are not medically necessary in this patient's foot contusion.

Rationale/Basis for Decision

This patient has been evaluated by _____ one on one as of two times by 6/12/03 and he found no specific problems or objective findings with this patient and felt that he

could return to work full duty as of 6/13/03. Once again, when he re-evaluated him for the third time on 3/25/04, he still had the same opinion. This physician has seen this patient three times. I agree with his assessment of contusion of the right foot. I agree that he only needed a self directed home exercise program and over the counter medications as of 6/12/03 and no further work-up. He had already had an extensive amount, in my opinion, of testing that was not medically indicated such as the electro neurodiagnostics. The three phase bone scan was normal. The EMG was normal. His x-rays have been normal. Therefore, as of 6/12/03 and _____ evaluation I feel this should have been end of treatment for this gentleman and office visits and billing rendered 10/7/03 and forward are not appropriate or supported as being necessary for this right foot contusion with an injury date of _____. This gentleman's condition of a right foot contusion would not be treated appropriately at this length of time post injury with chiropractic medicine or with biofeedback and psychological therapies. This would not be standard of care for the work related diagnosis and findings by _____ and testing results. Therefore, I would uphold the insurance carrier's decision in regards of dates of service 10/7/03 and charges.